IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOSEPH PETERS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No.
	)	
LIFE INSURANCE COMPANY OF NORTH AMERICA,	)	
	)	
Defendant.	)	

COMPLAINT

Now comes the Plaintiff, JOSEPH PETERS, by his attorneys, MARK D. DE BOFSKY, and DALEY, DE BOFSKY & BRYANT, and complaining against the Defendant, LIFE INSURANCE COMPANY OF NORTH AMERICA, a CIGNA company, he states:

Jurisdiction and Venue

1. Jurisdiction of this Court is based upon diversity of citizenship. The Plaintiff is a citizen of the State of Illinois while the Defendant is, on information and belief, a citizen of the State of Pennsylvania. The amount in controversy exceeds $75,000, exclusive of interest and costs. Accordingly, the court has subject matter jurisdiction pursuant to 28 U.S.C. § 1332. Although the controversy at issue here relates to benefits due under an employee benefit plan, the ERISA law is inapplicable since the policy at issue constitutes a "church plan," exempt from ERISA pursuant to 29 U.S.C. § 1003(b)(2).

2. Venue is appropriate in this district pursuant to 28 U.S.C. § 1391.

Nature of Action

3.. This is a claim seeking long-term disability insurance payments and life insurance pursuant to a waiver of premium on account of disability under two policies of insurance underwritten and insured by the Life Insurance Company of North America (LINA), a CIGNA company, for the benefit of employees of Loyola University of Chicago ("Loyola"), including the Plaintiff. Plaintiff brings this action claiming entitlement to the aforementioned benefits pursuant to a policy of group long-term disability insurance, Policy No. LK-960356 (a true and correct copy of which is attached hereto and by that reference incorporated herein as Exhibit "A") and a policy of group life insurance benefits, Policy No. FLX-960385 (a copy of which has not been made available to the Plaintiff despite request). Plaintiff also seeks penalties and attorneys' fees pursuant to 215 ILCS 5/155.

The Parties

4. The Plaintiff, Joseph Peters (DOB 10/xx/1950) ("Peters"), is and was a resident of Oak Brook, Illinois at all times relevant hereto.

5. The Defendant, LINA, is the underwriter and insurer of Group Policy Numbers LK-960356 and FLX-960385 issued to Loyola to provide, respectively, long-term disability benefits and life insurance benefits for its employees. At all times relevant hereto, LINA was engaged in the business of insurance and in the administration of benefits under the aforementioned policies of insurance within the Northern District of Illinois.

Statement of Facts

6. Peters was employed as an Attending Anesthesiologist and Assistant Professor of Anesthesiology at Loyola until October 2005, when he was forced to stop working due to symptoms caused by rheumatoid arthritis. Peters has not been actively employed since that date.

7. Peters experiences substantial pain and other symptoms resulting from the rheumatoid arthritis that prevents him from continuing to work in his profession. In addition, Peters suffers from chronic migraines, hypertension, and diabetes. Due to the combined effects of these conditions, Peters has been and remains unable to perform his former occupation or any occupation.

8. Subsequent to ceasing his employment, Peters made a claim for long-term disability (LTD) benefits under the LTD policy,[1] stating that beginning in October 2005, due to his condition, he met the Plan's definition of "disability," which states in relevant part that:

> The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:
> 1. unable to perform the material duties of his or her Regular Occupation; and
> 2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.
>
> After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:
> 1. unable to perform all the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
> 2. unable to earn 60% or more of his or her Indexed Earnings.

Exhibit A at 2.

9. Peters supported his claim for benefits with numerous medical records and reports supporting disability. However, despite overwhelming evidence, LINA denied his claim for LTD benefits on July 13, 2007.

10. In addition to his application for disability benefits, Peters also applied for life insurance Waiver of Premium under the life insurance policy, which Plaintiff has been informed and believes includes the following provisions:

[1] Peters's claim for benefits was made in April 2007. Peters indicated to LINA both in phone and written correspondence that the delay in his application was due to Loyola's failure to notify him he was entitled to LTD benefit coverage under the Plan. When Peters did become aware of his coverage, he made a timely application for benefits.

Benefit Waiting Period
9 months from the date of the Employee's Active Service ends.

Applicable Coverages
Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any.

Disabled
An Employee is Disabled if, because of Injury or Sickness, he or she is unable to perform all the material duties of any occupation for which he or she may be reasonably become qualified based on education, training or experience.

Termination of Waiver
Insurance will end for any Employee whose premiums are waived on the earliest of the following dates.
1. The date he or she is no longer Disabled.
2. The date he or she refuses to submit to any physical examination required by the Insurance Company.
3. The last day of the 12 month period of Disability during which he or she fails to submit satisfactory proof of continued Disability.
4. The date the Maximum Benefit Period for this benefit, if any, ends.

11. Peters submitted substantial medical evidence to support his claim for life insurance waiver of premium. However, LINA denied the claim on October 12, 2007.

12. On December 28, 2007, Peters submitted an appeal of LINA's decisions to deny his long-term disability benefits and life insurance waiver of premium which included additional supporting medical evidence. However, on February 20, 2008, LINA upheld its decision to deny Peters's claims, relying on the opinion of a non-examining doctor it retained to review Peters's file and ignoring without cause the opinions and conclusions of the doctors who have evaluated his fitness to perform anesthesiology.

13. In addition to his claims to LINA, Peters also applied for Social Security disability benefits. Peters was assisted in his claim by a representative hired by LINA to act both on his behalf and on LINA's behalf since LINA would benefit from the Social Security award because Social Security disability benefits offset long-term disability benefits payable. On August 28,

2007, the Social Security Administration (SSA) awarded Peters disability benefits, finding that he has been disabled since October 31, 2005. This award signified a finding by the SSA that Peters is unable to engage in "any substantial gainful activity." 42 U.S.C. §423(d)(1)(A) (definition of disabled under Social Security Act) (a true and correct copy of the Social Security decision is attached hereto and by that reference incorporated herein as Exhibit "B"). LINA was provided with a copy of the SSA's decision, as well as the entire claim record on which the decision was based, to consider as additional evidence before rendering a decision on Peters's appeal.

14. The determination by LINA to deny Peters's benefits is contrary to the terms of the Plan and has no rational support in the evidence. The decision is also contrary to the reports of all of the doctors who have evaluated Peters's fitness to work in his profession, as well as the findings of the Social Security Administration and other relevant evidence.

15. As a direct and proximate result of the foregoing, based on the evidence submitted to LINA establishing Peters has met and continues to meet the applicable disability definitions, he is entitled to all benefits due since October 2005, and such benefits must continue until he recovers from disability, dies, or reaches the age of 65, whichever comes first.

WHEREFORE, Plaintiff prays for the following relief:

A. That the court enter judgment in Plaintiff's favor and against Defendant and that the court order Defendant to pay disability income benefits to Plaintiff in an amount equal to the contractual amount of benefits to which he is entitled;

B. That the court order Defendant to pay Plaintiff prejudgment interest at a rate of 9% per annum on all benefits that have accrued prior to the date of judgment in accordance with 215 ILCS 5/357.9 or 5/357.9a;

C. That the court order Defendant to continue Plaintiff's life insurance benefits under a waiver of premium;

D. That the court determine and then declare that Defendant is required to continue paying Plaintiff benefits so long as he meets the policy terms and conditions for receipt of benefits;

E. That Plaintiff recover any and all other relief to which he may be entitled, as well as the costs of suit.

Count II

For Count II of his Complaint, Plaintiff states:

1.-16. Plaintiff realleges paragraphs 1-16 of Count I of his Complaint as paragraphs 1-16 of Count II and by that reference incorporates those allegations herein.

17. There is and was in effect in the State of Illinois at all times relevant hereto, a statute codified at 215 ILCS 5/155 which allows the court to assess penalties and attorneys' fees against an insurance company that acts vexatiously and unreasonably.

18. The foregoing described conduct constitutes an unreasonable and vexatious delay or refusal of payment on a claim since Defendant has refused to make indemnity payments despite the submission of valid and well-supported proofs of claim; and there is no legitimate dispute as to plaintiff's entitlement to benefits.

WHEREFORE, Plaintiff prays for the following relief:

A. That Plaintiff be awarded judgment in his favor and against the Defendant as prayed for in Count I of this Complaint.

B. That Defendant be assessed the maximum penalty allowable pursuant to 215 ILCS 5/155, and that Defendant be ordered to pay Plaintiff's attorney's fees and court costs; and

C. That Plaintiff recover any and all other relief to which he is entitled.

Dated: March 21, 2008

/s/ Mark D. DeBofsky

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One of the attorneys for the Plaintiff,
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A STOCK INSURANCE COMPANY

GROUP POLICY

08CV1705 EDA
JUDGE MORAN
MAGISTRATE JUDGE NOLAN

POLICYHOLDER:	Loyola University Chicago
POLICY NUMBER:	LK-960356
POLICY EFFECTIVE DATE:	January 1, 2004
POLICY ANNIVERSARY DATE:	January 1

This Policy describes the terms and conditions of coverage. It is issued in Illinois and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

Susan L. Cooper

Susan L. Cooper, Secretary

Gregory H. Wolf

Gregory H. Wolf, President

TL-004700

O/O v-2

EX A

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Premium Due Date

Premiums are due in arrears on the date coinciding with the day of the Policy Anniversary Date or the last day of the month, if earlier.

Initial Premium Rates

$.325 per $100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings for the insurance month prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed $16,667.

Classes of Eligible Employees

On the pages following the definition of eligible employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

If an Employee is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the date of the change in class.

Class 1 — All active regular Employees in active employment:

- Regular Full-time Employees, excluding Stritch Employees scheduled to work a minimum of 1,560 hours per year or who are classified as a .80 Full-time Employee (FTE).
- Regular Full-time Stritch Employees scheduled to work a minimum of 2,080 hours per year or who are classified as a 1.0 Full-time Employee (FTE).

Class 2 — All active Employees of the Employer who are classified as Officers, Deans, Administrative Department Heads or Faculty Members and who are:

- Regular Full-time Employees, excluding Stritch Employees scheduled to work a minimum of 1,560 hours per year or who are classified as a .80 Full-time Employee (FTE), or
- Regular Full-time Stritch Employees scheduled to work a minimum of 2,080 hours per year or who are classified as a 1.0 Full-time Employee (FTE).

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:	After one year of Active Service
For Employees hired after the Policy Effective Date:	After one year of Active Service

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Optimum Ability

1. for the first 24 months that benefits are payable, the greatest extent of work the Employee is able to do in his or her Regular Occupation;
2. after 24 months, the greatest extent of work the Employee is able to do in any occupation based on education, training or experience.

The Employee's ability to work is based on the following:

1. medical evidence submitted by the Employee;
2. consultation with the Employee's Physician; and
3. evaluation of the Employee's ability to work by not more than three Independent Experts if required by the Insurance Company.

There is no cost to the Employee for evaluation by an Independent Expert when required by the Insurance Company to determine Optimum Ability.

The Independent Expert must be:

1. licensed, registered or certified as required by the laws of the state in which the evaluation is made; and
2. acting within the scope of that license, registration or certificate.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	90 days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	$10,000 per month
Minimum Disability Benefit	The greater of $100 or 10% of an Employee's Monthly Benefit prior to any reductions for Other Income Benefits.

Disability Benefit Calculation
The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits, calculation of Optimum Ability and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits, and less the calculation for Optimum Ability. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Return to Work Incentive
During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows.

The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Indexed Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits and the calculation for Optimum Ability.
5. If the sum from 1. does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits and the calculation for Optimum Ability.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits, the calculation for Optimum Ability and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Calculation for Optimum Ability
The calculation for Optimum Ability is the earnings the Employee could earn if working at Optimum Ability, minus Disability Earnings.

Additional Benefits

Survivor Benefit

Amount of Benefit:	100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.
Maximum Benefit Period	A single lump sum payment equal to 3 monthly Survivor Benefits.

Maximum Benefit Period

Age When Disability Begins	Maximum Benefit Period
Under Age 60	The Employee's 65th birthday or the date the 60th Monthly Benefit is payable, if later.
Age 61	The date the 48th Monthly Benefit is payable.
Age 62	The date the 42nd Monthly Benefit is payable.
Age 63	The date the 36th Monthly Benefit is payable.
Age 64	The date the 30th Monthly Benefit is payable.
Age 65	The date the 24th Monthly Benefit is payable.
Age 66	The date the 21st Monthly Benefit is payable.
Age 67	The date the 18th Monthly Benefit is payable.
Age 68	The date the 15th Monthly Benefit is payable.
Age 69 and over	The date the 12th Monthly Benefit is payable.

TL-004774

SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:	After 3 months of Active Service
For Employees hired after the Policy Effective Date:	After 3 months of Active Service

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Optimum Ability

1. for the first 24 months that benefits are payable, the greatest extent of work the Employee is able to do in his or her Regular Occupation;
2. after 24 months, the greatest extent of work the Employee is able to do in any occupation based on education, training or experience.

The Employee's ability to work is based on the following:

1. medical evidence submitted by the Employee;
2. consultation with the Employee's Physician; and
3. evaluation of the Employee's ability to work by not more than three Independent Experts if required by the Insurance Company.

There is no cost to the Employee for evaluation by an Independent Expert when required by the Insurance Company to determine Optimum Ability.

The Independent Expert must be:

1. licensed, registered or certified as required by the laws of the state in which the evaluation is made; and
2. acting within the scope of that license, registration or certificate.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	180 days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	$10,000 per month
Minimum Disability Benefit	The greater of $100 or 10% of an Employee's Monthly Benefit prior to any reductions for Other Income Benefits.

Disability Benefit Calculation
The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits, calculation of Optimum Ability and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits, and less the calculation for Optimum Ability. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Return to Work Incentive
During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows.

The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Indexed Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits and the calculation for Optimum Ability.
5. If the sum from 1. does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits and the calculation for Optimum Ability.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits, the calculation for Optimum Ability and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Calculation for Optimum Ability
The calculation for Optimum Ability is the earnings the Employee could earn if working at Optimum Ability, minus Disability Earnings.

Additional Benefits

Survivor Benefit

Amount of Benefit:	100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.
Maximum Benefit Period	A single lump sum payment equal to 3 monthly Survivor Benefits.

Maximum Benefit Period

Age When Disability Begins	Maximum Benefit Period
Under Age 60	The Employee's 65th birthday or the date the 60th Monthly Benefit is payable, if later.
Age 61	The date the 48th Monthly Benefit is payable.
Age 62	The date the 42nd Monthly Benefit is payable.
Age 63	The date the 36th Monthly Benefit is payable.
Age 64	The date the 30th Monthly Benefit is payable.
Age 65	The date the 24th Monthly Benefit is payable.
Age 66	The date the 21st Monthly Benefit is payable.
Age 67	The date the 18th Monthly Benefit is payable.
Age 68	The date the 15th Monthly Benefit is payable.
Age 69 and over	The date the 12th Monthly Benefit is payable.

TL-004774

ELIGIBILITY FOR INSURANCE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date, or the day after he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired after more than 18 months, a new Eligibility Waiting Period must be satisfied. If a former Employee is rehired within 18 months, he or she is not required to satisfy a new Eligibility Waiting Period. Credit will be given for any time that was satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed and within one year becomes a member of an eligible class.

TL-004710

EFFECTIVE DATE OF INSURANCE

An Employee will be insured on the date he or she becomes eligible, if the Employee is not required to contribute to the cost of this insurance.

If an Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to any occupation for the Employer on a Full-time basis.

TL-004712

TERMINATION OF INSURANCE

An Employee's coverage will end on the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date the Employee is no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date the Employee is no longer in Active Service;
6. the date benefits end for failure to comply with the terms and conditions of the Policy.

Disability Benefits will be payable to an Employee who is entitled to receive Disability Benefits when the Policy terminates, if he or she remains disabled and meets the requirements of the Policy. Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered.

TL-007505.00

CONTINUATION OF INSURANCE

This Continuation of Insurance provision modifies the Termination of Insurance provision to allow insurance to continue under certain circumstances if the Insured Employee is no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the Termination of Insurance provisions.

Disability Insurance continues if an Employee's Active Service ends due to a Disability for which benefits under the Policy are or may become payable. Premiums for the Employee will be waived while Disability Benefits are payable. If the Employee does not return to Active Service, this insurance ends when the Disability ends or when benefits are no longer payable, whichever occurs first.

If an Employee's Active Service ends due to family medical leave approved timely by the Employer, insurance will continue for an Employee for up to 12 weeks, if the required premium is paid when due.

If an Employee's Active Service ends due to an academic leave of absence approved in writing by the Employer prior to the date the Employee ceases work insurance will continue for an Employee for up to 24 months if the required premium is paid.

If an Employee's Active Service ends due to layoff or any leave of absence approved in writing by the Employer prior to the date the Employee ceases work insurance will continue for an Employee for up to 12 months if the required premium is paid. An approved leave of absence does not include termination of employment.

If an Employee's Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, insurance for an Employee will continue until the earlier of:

a. the date the Employee's employment relationship with the Employer terminates;
b. the date premiums are not paid when due;
c. the end of the 30 day period that begins with the first day of such excused absence;
d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if an Employee's Active Service ends due to termination of employment, or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this provision will not apply.

If an Employee's insurance is continued pursuant to this Continuation of Insurance provision, and he or she becomes Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date he or she is scheduled to return to Active Service.

TL-004716

TAKEOVER PROVISION

This provision applies only to Employees eligible under this Policy who were covered for long term disability coverage on the day prior to the effective date of this Policy under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

A. This section A applies to Employees who are not in Active Service on the day prior to the effective date of this Policy due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, the Insurance Company will insure an Employee to which this section applies against a disability that occurs after the effective date of this Policy for the affected employee group. This coverage will be provided until the earlier of the date: (a) the employee returns to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day the employee was not in Active Service. The Policy will provide this coverage as follows:

   1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.

2. If the disability is not a c[illegible]ed disability under the Prior Plan solely [illegible]use the plan terminated, benefits payable under this Policy for that disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods and partial satisfaction of pre-existing condition limitations.

B. The Elimination Period under this Policy will be waived for a Disability which begins while the Employee is insured under this Policy if all of the following conditions are met:

1. The Disability results from the same or related causes as a Disability for which monthly benefits were payable under the Prior Plan;
2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
3. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;
4. The Disability begins within 6 months of the Employee's return to Active Service and the Employee's insurance under this Policy is continuous from this Policy's Effective Date.

C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the pre-existing condition limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied

Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TL-005108

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits to each class of Insureds.

Disability Benefits
The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company, at his or her own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Insurance Company will require continued proof of the Employee's Disability for benefits to continue.

Elimination Period
The Elimination Period is the period of time an Employee must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation
The Disability Benefit Calculation is shown in the Schedule of Benefits. Monthly Disability Benefits are based on a 30 day period. They will be prorated if payable for any period less than a month. If an

Employee is working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive

The Return to Work Incentive is shown in the Schedule of Benefits. An Employee may work for wage or profit while Disabled. In any month in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive applies.

The Insurance Company will, from time to time, review the Employee's status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit

The Insurance Company will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits

An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received (or assumed to be received*) by the Employee or his or her dependents under:
   - the Canada and Quebec Pension Plans;
   - the Railroad Retirement Act;
   - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
   - any sick leave or salary continuation plan of the Employer;
   - any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits the Employee or any third party receives (or is assumed to receive*) on his or her own behalf or for his or her dependents; or which his or her dependents receive (or are assumed to receive*) because of his or her entitlement to such benefits.
3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts received (or assumed to be received*) by the Employee or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of an Employee's entitlement to benefits.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits
Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating the Employee's Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments
Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits
The Insurance Company will assume the Employee (and his or her dependents, if applicable) are receiving benefits for which they are eligible from Other Income Benefits. The Insurance Company will reduce the Employee's Disability Benefits by the amount from Other Income Benefits it estimates are payable to the Employee and his or her dependents.

The Insurance Company will waive Assumed Receipt of Benefits, except for Disability Earnings for work the Employee performs while Disability Benefits are payable, if the Employee:

1. provides satisfactory proof of application for Other Income Benefits;
2. signs a Reimbursement Agreement;
3. provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Insurance Company determines that further appeals are not likely to succeed; and
4. submits satisfactory proof that Other Income Benefits were denied.

The Insurance Company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until the Employee actually receives them.

Social Security Assistance
The Insurance Company may help the Employee in applying for Social Security Disability Income (SSDI) Benefits, and may require the Employee to file an appeal if it believes a reversal of a prior decision is possible.

The Insurance Company will reduce Disability Benefits by the amount it estimates the Employee will receive, if the Employee refuses to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment
The Insurance Company has the right to recover any benefits it has overpaid. The Insurance Company may use any or all of the following to recover an overpayment:
1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when the Employee dies, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability

A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, the Employee returns to work in his Regular Occupation for less than 6 consecutive months; and
3. if the Employee earns less than the percentage of Indexed Earnings that would still qualify him or her to meet the definition of Disability/Disabled during at least one month.

Any later period of Disability, regardless of cause, that begins when the Employee is eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, the Employee must satisfy a new Elimination Period.

LIMITATIONS

Pre-Existing Condition Limitation

The Insurance Company will not pay benefits for any period of Disability caused by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or consulted a Physician within 3 months before his or her most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after an Employee has been in Active Service for a continuous period of 3 months during which the Employee has received no medical treatment, care or services in connection with the pre-existing conditions or is covered for at least 12 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

TL-007500.14

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability

If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in a Rehabilitation Plan and assessment at our expense. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The Insurance Company will work with the Employee, the Employer and the Employee's Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at the Insurance Company's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

TL-007501.00

Survivor Benefit
The Insurance Company will pay a Survivor Benefit if an Employee dies while Monthly Benefits are payable. The Employee must have been continuously Disabled before the first benefit is payable. These benefits will be payable for the Maximum Benefit Period for Survivor Benefits.

Benefits will be paid to the Employee's Spouse. If there is no Spouse, benefits will be paid in equal shares to the Employee's surviving Children. If there are no Spouse and no Children, benefits will be paid to the Employee's estate.

"Spouse" means an Employee's lawful spouse. "Children" means an Employee's unmarried children under age 21 who are chiefly dependent upon the Employee for support and maintenance. The term includes a stepchild living with the Employee at the time of his or her death.

TL-005107

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:
1. the date the Employee earns from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to him or her at that time;
2. the date the Insurance Company determines he or she is not Disabled;
3. the end of the Maximum Benefit Period;
4. the date the Employee dies;
5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date the Employee is no longer receiving Appropriate Care;
7. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

Extension of Benefits after Termination
Payment of Benefits will not be affected by termination of the Policy as long as the Disability begins while the Policy is inforce.

TL-007502.14

EXCLUSIONS

The Insurance Company will not pay any Disability Benefits for a Disability that results directly from:
1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

TL-007503.14

CLAIM PROVISIONS

Notice of Claim
Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Claim Forms
When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision
Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company.

Time of Payment
Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which the Insurance Company is liable, will be paid at that time.

To Whom Payable
Disability Benefits will be paid to the Employee. If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed custody and support.

If an Employee dies while any Disability Benefits remain unpaid, the Insurance Company may, at its option, make direct payment to any of the following living relatives of the Employee: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of the Employee's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Insurance Company from all liability for any payment made.

Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based ~~on~~ the rates currently in force, the plan and the amount of insurance in effect.

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 36 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.

5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Reinstatement of Insurance
An Employee's insurance may be reinstated if it ends because the Employee is on an unpaid leave of absence.

An Employee's insurance may be reinstated only if reinstatement occurs within 12 weeks from the date insurance ends due to an Employer approved unpaid leave of absence or must be returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA). For insurance to be reinstated the following conditions must be met.

1. An Employee must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. A written request for reinstatement must be received by the Insurance Company within 31 days from the date an Employee returns to Active Service.

Reinstated insurance will be effective on the date the Employee returns to Active Service. If an Employee did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence, credit will be given for any time that was satisfied.

TL-004720

GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age
If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates
A certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits
The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error
A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency
The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service
An employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Appropriate Care
Appropriate Care means the determination of an accurate and medically supported diagnosis of the Employee's Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Consumer Price Index (CPI-W)
The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Disability Earnings
Any wage or salary for any work performed for any employer during the Employee's Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee
For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Good Cause
A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

Indexed Earnings
For the first 12 months Monthly Benefits are payable, Indexed Earnings will be equal to Covered Earnings. After 12 Monthly Benefits are payable, Indexed Earnings will be an Employee's Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of the Employee's Indexed Earnings during the preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury
Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurability Requirement
An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage; the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a company in effect on the day prior to that company's addition to this Policy after the Policy Effective Date.

Regular Occupation
The occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan
A written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness
Any physical or mental illness.

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PENNSYLVANIA

We, Loyola University Chicago, whose main office address is Chicago, IL, hereby apply to the Life Insurance Company of North America for Policy Number LK-960356.

We approve and accept the terms of this Policy.

This application is to be signed in duplicate. One part is to be attached to the Policy; the other part is to be returned to the Life Insurance Company of North America.

This application supersedes any previous application for this Policy.

Loyola University Chicago
(Full or Corporate Name of Applicant)

Signed at: _____ By: _____
(Signature and Title)

On: _____ Witness: _____
(To be signed by Licensed Resident Agent where required by law)

TL-004778 (This Copy Is To Remain Attached To The Policy)

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PENNSYLVANIA

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Loyola University Chicago
(Full or Corporate Name of Applicant)

Signed at: _____ By: _____
(Signature and Title)

On: _____ Witness: _____
(To be signed by Licensed Resident Agent where required by law)

TL-004778 (This Copy Is To Be Returned To Us)

NOTICE

This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:

Illinois Department of Insurance
Consumer Division or Public Services Section
Springfield, Illinois 62767

OR

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192
1-800-441-1832

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by insurers through the Association is not unlimited, however, as noted in below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations or exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(312) 714-8080

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes and Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") [215 ILCS 5/531.01, et seq.]. The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association.

a) Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

1) life insurance, health insurance, and annuity contracts;
2) life, health or annuity certificates under direct group policies or contracts;
3) unallocated annuity contracts; and
4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities.

The beneficiaries, payees or assignees of such persons are also protected, even if they live in another state.

b) Exclusions from Coverage:

The Guaranty Association does not provide coverage for:

1) any policy or portion of a policy for which the individual has assumed the risk;
2) any policy of reinsurance unless an assumption certificate was issued;
3) interest rate guarantees which exceed certain statuary limitations;
4) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association or natural persons benefit plan or government lottery;
5) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
6) any stop loss insurance.

In addition, persons are not protected by the Guaranty Association if:

1) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
2) their policy was issued by an organization which is not a member insurer of the Association.

c) Limits on Amounts of Coverage:

1) The law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
   A) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
   B) with respect to any one life, regardless of the number of policies, contracts, or certificates:
      i) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
      ii) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
      iii) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

2) However, in no [illegible] Condominium Association liable for more than $300,000 with respect to any one individual.

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Northeastern Program Service Center
1 Jamaica Center Plaza
Jamaica, New York 11432-3898
Date: August 28, 2007
Claim Number: 040-46-7678HA

000772 MCSM71 N3 2.200

JOSEPH E PETERS
144 SADDLE BROOK DRIVE
OAK BROOK, IL 60523-2663

You are entitled to monthly disability benefits beginning April 2006.

The Date You Became Disabled

We found that you became disabled under our rules on October 31, 2005.

However, you have to be disabled for 5 full calendar months in a row before you can be entitled to benefits. For these reasons, your first month of entitlement to benefits is April 2006.

What We Will Pay And When

- You will receive $29,710.00 around September 3, 2007.
- This is the money you are due for April 2006 through August 2007.
- Your next payment of $1,774.00, which is for September 2007, will be received on or about the third Wednesday of October 2007.
- After that you will receive $1,774.00 on or about the third Wednesday of each month.
- These and any future payments will go to the financial institution you selected. Please let us know if you change your mailing address, so we can send you letters directly.

The day we make payments on this record is based on your date of birth.

Enclosure(s):
Pub 05-10153
Pub 05-10058

EX B

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See Next Page

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rounding. The amount you actually receive(s) may differ from your full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums. We must also round down to the nearest dollar.

Beginning Date	Benefit Amount	Reason
April 2006	$1,718.00	Entitlement began
December 2006	$1,774.60	Cost-of-living adjustment

Information About Representative's Fees

Your representative must receive approval from the Social Security Administration before a fee can be charged. If the representative wants to charge a fee, a request for approval must be sent to us as soon as all work for you is finished. If no fee will be charged, we should also be told right away.

Any request for fee approval should be sent to:

Northeastern Program Service Center
1 Jamaica Center Plaza
Jamaica, New York 11432-3898

Other Social Security Benefits

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for another kind of Social Security benefit in the future, you will have to file another application.

Your Responsibilities

The decisions we made on your claim are based on information you gave us. If this information changes, it could affect your benefits. For this reason, it is important that you report changes to us right away.

We have enclosed a pamphlet, "What You Need To Know When You Get Disability Benefits". It will tell you what must be reported and how to report. Please be sure to read the parts of the pamphlet which explain what to do if you go to work or if your health improves.

A provider of employment or vocational rehabilitation services may contact you about getting help to go to work. The provider may be a State vocational rehabilitation agency or a provider under contract with the Social Security Administration.

If you go to work, special rules allow us to continue your cash payments and health care coverage. For more information about how work and earnings affect disability benefits, call or visit any Social Security office and ask for the following publications:

- Social Security - Working While Disabled...How We Can Help (SSA Publication No. 05-10095).
- Social Security - If You Are Blind--How We Can Help (SSA Publication No. 05-10052).

Other Information

We are sending a copy of this notice to LORI FIALA.

Do You Disagree With The Decision?

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case. We will correct any mistakes. We will review those parts of the decision which you believe are wrong and will look at any new facts you have. We may also review those parts which you believe are correct and may make them unfavorable or less favorable to you.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a Form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim". It contains more information about the appeal.

Things To Remember For The Future

Doctors and other trained staff decided that you are disabled under our rules. However, we must review all disability cases. Therefore, we will review your case in 5 to 7 years. We will send you a letter before we start the review. Based on that review, your benefits will continue if you are still disabled, but will end if you are no longer disabled.

If You Have Any Questions

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-630-852-2831. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
7440 PROVIDENCE DR
WOODRIDGE, IL 60517

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Michael J. Astrue
Commissioner
of Social Security